that they can easily be rendered totally helpless by circumstance, and a forced confrontation with their own mortality. "Secondary wounding" with extension of the trauma can occur when medical and other caregivers manifest attitudes that suggest disbelief or blaming the patients for causing their own trauma. Implications that trauma survivors should have been more cautious, more intelligent, more resistant, or more morally outraged tend to be directed particularly to the victims of human-caused disasters. This unnecessary worsening of the original trauma, when based on a health worker's ignorance, burnout, or personal belief system, can be avoided. Secondary wounding can also occur at the hands of fellow trauma survivors, who happen, at that point in time, to be coping with their own losses by the use of denial of the adverse consequences.

A natural result of primary and secondary trauma is internalization of the victim status. Though no longer in a traumatic situation, such patients adopt the disaster and its aftermath as the central, dominating event in their lives. They then use it to determine their general worldview and the way they think and act. Secondary prevention efforts must address these attitudes that underlie the "permanent victim" status: intolerance of one's mistakes and fear of seeming defective, weak, or cowardly. Research has shown that primary prevention in the form of rapid, brief psychiatric intervention and the use of support groups can minimize the development of persistent posttraumatic stress disorder symptoms. The short-term use of benzodiazepine or antihistamine agents with anxiolytic or hypnotic effects can be helpful in selected patients not prone to chemical dependency.

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Sexual Victimization and Physical Symptoms in Women

THERE IS A GROWING AWARENESS that childhood sexual abuse causes not only psychological sequelae but also continuing medical morbidity. Sexual victimization can be associated with several long-term physical effects.

Several recent, well-designed studies have associated sexual victimization with a variety of medical conditions, particularly chronic pelvic pain and the irritable bowel syndrome. Surveys of participants of health maintenance organizations have also shown increased rates of smoking, obesity, excessive alcohol and drug use, pregnancy before age 18, abortions, multiple sex partners, high-risk sexual contacts, a greater number of unintended pregnancies, earlier first intercourse, and a decreased frequency of Pap smears for survivors. They have also been shown to be higher users of medical care resources, averaging two to three times the usual rates of clinic attendance.

The health care use of survivors may also be influenced by social and psychological factors. A higher use may arise from the inability of a woman's family of origin to protect her from the abusive relationship or to provide early medical intervention and ensuing psychological care. Subsequent contacts with health care professionals may afford opportunities for the survivors to obtain this emotional support from their medical caregivers, thus reinforcing somatization and increased health care use.

The Council on Scientific Affairs of the American Medical Association has recently issued a special report declaring the need for an increased awareness on the part of physicians of all forms of violence against women. The report suggested guidelines for physician training in assessing past victimization as part of the routine care of women. Given the prevalence of sexual victimization, it is likely that physicians come into daily contact with a substantial number of sexual victimization survivors. Greater awareness of the long-term biopsychosocial effects of sexual victimization may be a critical aspect of improving care for these patients.

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Role of Newer Antidepressants

NEWER ANTIDEPRESSANTS are gradually replacing old tricyclic antidepressants because of comparable efficacy with fewer side effects and a much lower risk of death from overdose. Newer-generation antidepressants include trazodone hydrochloride, bupropion hydrochloride, and the selective serotonin reuptake inhibitors fluoxetine hydrochloride, sertraline hydrochloride, and paroxetine.

Trazodone and bupropion, unlike tricyclic antidepressants, are ineffective for panic. Anticholinergic effects—dry mouth, blurred vision, constipation, and urinary retention—and cardiovascular effects are less with the newer drugs than with tricyclic antidepressants. Weight loss can occur with bupropion and fluoxetine. Overdose lethality is rare with these newer drugs.

Newer antidepressants, like tricyclic antidepressants, show efficacy at two to six weeks, and about 50% to 70% of depressed patients obtain benefit. Patients who partially respond or do not respond may benefit from lithium or triiodothyronine augmentation or by changing to a different class of drug, such as from trazodone to serotonin reuptake inhibitors and serotonin reuptake inhibitors to bupropion.

Trazodone is highly sedating, and dose titration to the maximum tolerated dose is required in the 100-mg to 600-mg at bedtime range based on daytime sedation. Trazodone, 50 mg to 100 mg, is widely used as a hypnotic in lieu of potentially addicting medications. It may wors-